State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services
SANDRA SHEWRY
Director

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April 11, 2005

MMCD ALL Plan Letter 05005

TO: County Organized Health System Plans (COHS)
Geographic Managed Care (GMC) Plans
Prepaid Health Plans (PHP)
Two-Plan Model Plans
AIDS Health Care Foundation

SUBJECT: All Plan Letter 04006 regarding Senate Bill 59 Notice of Action Letters

Purpose:

This letter updates information included in Medi-Cal Managed Care Division (MMCD) All Plan Letter (APL) 04006 issued on November 1, 2004.

Background:

MMCD APL 04006 was issued as a result of Senate Bill (SB) 59 (Stats.1999, Chapter 539) which added section 14087.41 to the Welfare and Institutions Code. Section 14087.41 required the Department of Health Services (DHS) to develop a simple Notice of Action form for Medi-Cal Managed Care health plans to use when notifying Medi-Cal Members of denials, modifications, deferrals and terminations of requested medical services. APL 04006 included a version of the Notice of Action (NOA) letter developed for each type of action and two versions of a form titled "Your Rights" - one for Knox-Keene licensed health plans and one for non-Knox-Keene licensed health plans - which must be sent with each NOA letter. The "Your Rights" form includes information advising the Member of his/her rights to file a grievance with the health plan, request a State hearing, and/or request an Independent Medical Review (IMR); it also provides information about how to obtain free legal help.

Since APL 04006 was published, several issues were raised regarding non-Medi-Cal required language that was not included in the NOA letters attached to the APL and other information that required correction.

These issues include: the Department of Managed Health Care (DMHC) requires that the language in Health and Safety Code Section 1368.02(b) be included verbatim in all NOA letters sent to Knox-Keene licensed health plan enrollees; the information in the "Your Rights" attachment of the APL had incorrect IMR information; the "Form To File A State Hearing" had an incorrect address; and the IMR form attached to the APL was outdated.

In order to accommodate Knox-Keene licensed Medi-Cal health plans in maintaining their compliance with the DMHC requirements, DHS has replaced the IMR language in the "Your Rights" attachment for Knox-Keene licensed health plans with the Health and Safety Code language. An updated version of the "Your Rights" attachment and the current IMR form are attached to this letter.

There is a typographical error in the P.O. Box number of the address on the "Form To File A State Hearing" attachment sent with the APL. The correct address is:

California Department of Social Services
State Hearing Division
P.O. Box 944243, MS 19-37
Sacramento, CA 94244-2430

An updated version of the "Form To File A State Hearing" is attached to this letter.

Full translation of member informing materials has been, and continues to be, a requirement of Medi-Cal Managed Care health plans since MMCD Policy Letter 99-04 was issued in 1999. APL 04006 specifies the time frames for advising a member of a decision to deny, modify, defer or terminate a request for medical services. In addition to the above, an issue was raised regarding the feasibility of translating the Member specific clinical rationale that must be inserted into the NOA letters and complying with the time limits for sending the NOA letters to Members.

Action Required:

Knox-Keene licensed Medi-Cal managed care health plans must use the updated versions of the "Your Rights" form, the "Form to File A State Hearing", and current IMR form attached to this letter, in place of the ones included with APL 04006. In addition, the current version (10/2003) of the IMR form can be found by accessing the DMHC website at http://www.dmhc.ca.gov. Please check the website periodically to ensure use of the most current IMR form. Your MMCD Contract Manager will send to you an electronic version of the updated "Your Rights", "Form To File A State Hearing", and IMR attachments within 30 days of the date of this letter.

Full translation of member informing materials is a contract requirement with which every attempt should be made to comply; however, MMCD understands the challenge of translating the Member specific clinical rationale statement that must be inserted into NOA letters and complying with timeliness requirements. In cases where translation of the individualized statement would jeopardize compliance with the mailing time limits, MMCD will accept NOA letters where the individualized statement is written in English; however, the body of the letter must be translated and a sentence in the Members language must be inserted in the area of the individualized statement that explains how the Member can obtain a verbal translation. The body of the letter is defined as the entire content of the letter with the exception of the individualized clinical statement and Health Plan specific information. In addition, Plans must provide a written translation of the individualized statement if specifically requested by the Member.

All Plan Letter 04-006 is still in effect and Medi-Cal Managed Care health plans are currently required to use the NOA letters included with that APL. Plans are not authorized to make any other changes to the NOA letters or the "Your Rights" attachments besides the ones indicated in this letter.

If you have any questions or require additional information, please contact your Contract Manager.

Sincerely,

Vanessa M. Baird

Vanessa M. Baird, MPPA, Chief
Medi-Cal Managed Care Division

Enclosure

YOUR RIGHTS
UNDER MEDI-CAL MANAGED CARE

If you do not agree with this decision, you may:

- Ask for a "State Hearing"
- File a grievance with your health plan
- Ask for an "Independent Medical Review (IMR)"

You can file a grievance with your health plan **and** ask for a State Hearing at the same time.

You may have to file a grievance with your health plan **before** you can ask for an IMR, except in some cases.

You will not have to pay for any of these.

STATE HEARINGS

You may ask for a State Hearing in writing. Fill out the enclosed form or send a letter to:

California Department of Social Services
State Hearing Division
P.O. Box 944243, **MS 19-37**
Sacramento, CA 94244-2430

Alternatively, you may call **1-800-952-5253** to ask for a State Hearing. This number can be very busy so you may get a message to call back later. If you have trouble hearing or speaking, you can call **TDD 1-800-952-8349**.

If you want a State Hearing, you must ask for it within 90 days from the date of this letter, **UNLESS you and** *(insert the name of the treating provider)* **want to keep your treatment going** that this Notice of Action is stopping or reducing. **Then, you must ask for a State Hearing within 10 days from the date this letter was postmarked or personally delivered to you, or before the effective date of the action which you are disputing.** Please state that you want to keep getting your treatment during the hearing process.

If you use the enclosed form or write a letter to ask for a State Hearing, be sure to include your name, address, phone number, Social Security Number, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address and phone number to the form or letter. If you need a free interpreter, tell us what language you speak.

After you ask for a hearing, it could take up to 90 days for your case to be decided and an answer sent to you. If you believe waiting that long will seriously jeopardize your life or health or ability to attain, maintain or regain maximum function, ask your doctor or *(insert name of health plan)* for a letter. The letter must explain how waiting for up to 90 days for your case to be decided will seriously jeopardize your life or health or ability to

attain, maintain or regain maximum function. Then ask for an **expedited hearing** and provide the letter with your request for hearing.

LEGAL HELP

You may speak for yourself at the State Hearing or have someone else speak for you, including a relative, friend or attorney. You must get the other person yourself. You may be able to get free legal help. Call the *(insert the name and phone number of the county's consumer rights hotline)*. You may also call the local Legal Aid Society in your county *(insert phone number or reference to "Legal Services" in yellow pages)*.

GRIEVANCES

You may ask for a grievance by calling *(insert health plan's name)* at *(insert telephone number)* or by sending a letter to *(insert plan address)*. Your doctor will have grievance forms. *(Insert health plan's name)* will review its decision based on your grievance and you will get an answer within 30 days. If you think that waiting 30 days will harm your health, be sure to say why when you ask for your grievance. Then you might be able to get an answer within 3 calendar days.

DEPARTMENT OF MANAGED HEALTH CARE

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at *(insert health plan's telephone number)* and use your health plan' s grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department' s Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online."

OTHER INFORMATION

(*Health plan name*) wants to try to help you with your problem, so we hope you will call us first.

State of California – Business, Transportation and Housing Agency
Department of Managed Health Care
INDEPENDENT MEDICAL REVIEW APPLICATION
DMHC 20-086 Rev (10/2003)

INDEPENDENT MEDICAL REVIEW APPLICATION

PATIENT INFORMATION

(If a representative of the patient/enrollee is filling out this form, please provide your contact information on a separate sheet.)

First Name _____ **Middle Initial** _____ **Last Name** _____ **Date of Birth** ___/___/___

Address _____ **Telephone #** _____

City _____ **State** _____ **Zip** _____ **E-Mail** _____

Name of HMO/ Health Plan _____ **Membership I.D.** _____ **Social Security Number** _____

- **Are you a Medi-Cal Managed Care beneficiary?** **YES NO (circle one)**
- **Are you a Medicare or Medicare Plus Choice beneficiary?** **YES NO (circle one)**
- **Have you participated in your HMO's or health plan's grievance process?** **YES NO (circle one)**
- **Has the requested medical treatment or service already been received?** **YES NO (circle one)**

YOUR CONDITION (Please feel free to continue on a separate page or attach supporting and related documents.)

- **Please provide a short description of your medical condition or diagnosis** _____
- **What is the medical treatment or service you are requesting?** _____
- **How would you like to see this case resolved?** _____
- **Do you have a condition that is a serious threat to your health? YES NO If YES, please explain** _____
- **Why did your HMO or health plan say it was denying, modifying or delaying services, treatment or reimbursement for emergency care? (check one below)**

_____**Not Medically Necessary** _____ **Experimental or Investigational** **Other:** _____

Please list the physicians who have treated you for this condition. Include their contact information and note whether they were within or outside of your HMO or health plan's network. (Again, feel free to continue on a separate page.)

_____

"I hereby request Independent Medical Review of my dispute with the Health Plan. I authorize the release of any and all of my medical records and information, of any type, of or pertaining to the scope of this authorization including medical, mental health, substance abuse, HIV records, diagnostic imaging reports, and any other type of non-documentary records, as well as pertinent non-medical records and information. This authorizes release by and among all medical providers, the enrollee's Health Plan, the California Department of Managed Health Care and its consultants, and any Independent Medical Review Organization or reviewers authorized by the Department of Managed Health Care to review grievances regarding health care services. Release and disclosure are authorized only to the extent any of those persons or entities may deem appropriate for a purpose consistent with the review of a grievance or complaint regarding health care services. This authorization will expire one year from the date below, except as regarding the Department's internal use or as otherwise allowed by law. The expiration will apply to all information not previously released pursuant to this authorization. This authorization may be revoked or withdrawn at any time. A revocation or withdrawal will apply to all information not previously released pursuant to this authorization. I attest that the information provided is accurate and truthful."

Enrollee's Signature _____ **Date** _____

State of California – Business, Transportation and Housing Agency
Department of Managed Health Care
INDEPENDENT MEDICAL REVIEW APPLICATION
DMHC 20-086 Rev (10/2003)

INDEPENDENT MEDICAL REVIEW

APPLICATION INSTRUCTIONS

Thank you for contacting the Department of Managed Health Care regarding your HMO coverage. We know this is a difficult time and we are here to help. Our Independent Medical Review process can help you when treatment or services have been denied, delayed, or modified by your HMO because the HMO claims that the service is not medically necessary or is experimental. If you need assistance in completing this application form or have any questions, please contact us at 1-888-HMO-2219.

- **This one page application form is all you need to apply for an Independent Medical Review – you do not pay anything for this review.** Providing the requested documents will likely help accelerate the review process.

- Please be aware that failing to apply for Independent Medical Review may forfeit other statutory rights to pursue legal action against your HMO regarding the disputed health care service. Your application may be rejected if it is not submitted within six months of being denied the disputed health care service.

THE APPLICATION

- Please complete the application as fully and accurately as possible. When describing your medical condition, list the physician's diagnosis, e.g., diabetes, cancer, and stroke. Please give us the name of the denied medical service or treatment, or describe it as closely as you can. If available, please provide copies of correspondence about the disputed treatment from your medical group and HMO and attach any other materials or correspondence regarding the disputed service you wish the Department to consider in evaluating your application.

- When listing physicians, please identify those who have seen you for this condition, or from whom you have requested medical service or treatment, or who have recommended for or against you receiving the medical service or treatment. Also identify which physician is your primary care provider (regular physician). Please note whether or not these physicians are within your HMO's network.

- **Please forward documentation and this form, by facsimile or mail, to: Department of Managed Health Care, HMO Help Center, IMR Unit, 980 Ninth Street, Suite 500, Sacramento, CA 95814. If you have any questions, the Department can be reached at 888-HMO-2219, or by fax at 916-229-4328. You will be advised by letter as soon as your case has been accepted for Independent Medical Review.**

- The HMO will be required to provide all medical records in its possession or that are available from contracting providers. **If you have seen non-contracting providers regarding the disputed care, you should take immediate steps to obtain copies of your records from those providers in order to submit them in time for review.** You should submit any all records, documents, or information related to the HMO's denial that you want considered by the reviewers. Please submit copies since originals cannot be returned.

NOTICE REQUIRED BY THE INFORMATION PRACTICES ACT
(California Civil Code Section 1798.17)

The personal information you are being asked to provide to the HMO Help Center is sought pursuant to the laws, primarily the Knox-Keene Act, which authorize and direct the Department of Managed Health Care to regulate health plans and investigate the complaints of health plan enrollees. Such information is primarily used in the investigation of your dispute with the health plan and to obtain an independent medical review. Providing such information is voluntary, not mandatory. However, if you choose not to provide the information, the investigation of your complaint, obtaining an independent medical review and the Department's regulatory functions may be impeded. As a result of the independent medical review and any other investigation, we may disclose such information, as necessary, to the health plan and an independent medical review organization, as well as other government agencies for regulatory and enforcement purposes and as otherwise allowed by law, such as the California Information Practices Act. You have a right to access your personal information by contacting the DMHC Records Request Coordinator, Department of Managed Health Care, Office of Legal Services, 980 Ninth Street, Suite 500, Sacramento, CA 95814-2725, (916) 322-6727.

FORM TO FILE A STATE HEARING

You can ask for a State Hearing by calling: 1-800-952-5253.
TDD users, call 1-800-952-8349.
Or you can fill out this form and FAX it to State Hearing Support at 916-229-4110.

Or you can mail this page to:

California Department of Social Services
State Hearing Division
P.O. Box 944243, MS 19-37
Sacramento, CA 94244-2430

For free help filling out this form, call the legal help phone number listed on 'Your Rights.'

I do not agree with the decision about my health care. Here's why:

_____
_____
_____
_____
_____

(If you need more space, use another piece of paper. Make a copy for your records.)

Check these boxes only if they apply to you:

(1) ☐ I want the person named below to represent me. She/he can see my medical records that relate to this hearing, come to the hearing, and speak for me.

Name: _____
Address: _____ Phone Number: _____
_____

(2) ☐ I need a free interpreter. My language or dialect is:
_____

(3) ☐ I also want to file a grievance against the health plan. I understand the State will send my health plan a copy of this form.

(4) ☐ My situation is **urgent**. I need a quick decision and cannot wait 90 days because: (Explain what may happen without a quick decision. As discussed in the "Your Rights" information notice, you will also need a letter from your doctor or health plan if you want an expedited hearing).

_____
_____
_____
_____
_____
_____

(5) ☐ Please continue the service my Plan has stopped until my hearing.

My Name: _____ My Social Security Number: _____
Address: _____
_____ Phone Number: _____

My signature: _____ Today's Date: _____
(After you complete this form, make a copy for your records.)